BPA Confidential Client Intake Form

State of Idaho Substance Use Disorder Treatment System

SECTION A: CLIENT INFORMATION

01.Legal Last Name:	02.Legal First Name:	03.Legal Middle Initial:	04.Suffix:
05.Alias/Nickname:		06.SS#:	07.DOB:
08.Physical Address:			09.Apt/Trlr.#:
10.City:	11.State:	12.Zip Code:	13.Resident County:
14.Primary Phone #:	15.Marital Status:	16.Gender:	17.Ethnicity:
18.Race:	19.Employment Status:	20.Head of Household:	21.Living Arrangement:
22. # of Children in Home:	23.Highest Grade Completed:	24.Income Source	25.Veteran Status:
26.Health Insurance:	27.If Medicaid Enter #:	28.Receiving WIC:	29.Payment Source: Other Government
30.Open CPS Case:	31.Recent Domestic Violence:	32.Now Pregnant:	33.HIV Test:
34.IV-Usage:	35.Opiate Replacement Therapy:	36.Psych. Problems:	37.Client Type:
38.Client Target:	39.Admission Type: Initial Admission	40.Treatment Setting: Freestanding	

41.Number of Prior Treatments:	42.Types of Treatments Attended:	43.# of Arrests in last 30 Days:

44. The number of times the client has attended a self-help program in the 30 days preceding the date of admission into treatment services. (includes attendance at AA, NA and other self-help/mutual support groups focused on recovery from substance abuse and dependence.

Mark Only One

a.No Attendance: ☐ b.(1-3) Times past Month: ☐ c.(4-7) Times past Month: ☐

d.(8-15) Times past Month: ☐ e.(16-30) Times Past Month: ☐ f.Not Collected: ☐

g. Unknown ☐ h.Attendance in past month but frequency unknown: ☐

SECTION B: COLLATERAL CONTACT INFORMATION (Friends, Relatives used to follow up with clients post discharge)

01.Person's Name:	02.Relationship to Client:	03.Phone #:	04.Phone Type:
05.Person's Name:	06.Relationship to Client:	07.Phone #:	08.Phone Type:

SECTION C: SUBSTANCE USE (Prior to incarceration if applicable)

1.

Substance Use	Drug of Choice	Route of Administration	Age of First Use	Frequency of Use	Last Time Used
Primary	a.	b.	c.	d.	e.
Secondary	f.	g.	h.	i.	j.
Tertiary	k.	l.	m.	n.	o.

SECTION D: REFERRAL TYPE

Criminal Justice Involvement

01.Adult Felon:	09.IDOC #:	17.Supervising County:
02.Probation:	10.DHW Re-Entry:	18.Felony Drug Court:
03.Parole:	11.Currently Incarcerated:	19.DUI Court:
04.Supervised:	12.Transferred from TC or ND:	20.Juv. Drug Court:
05.Adult Misdemeanor:	13.Client Transferred from Rider	21.Mental Health Court:
06.Adolescent Misd:	14.Client Topped out of Prison:	22.Juv. Mental Health Court:
07.Risk of Revocation:	15.Easter Seals/Goodwill:	23.Child Protection Drug Court:
08.ATR:	16.Idaho Code:	24.Referral Source:

SECTION E: REFERRAL INFORMATION (To include Probation, Parole Officers, Coordinators & IDOC Case Managers)

01. Printed Referral Name:	02.Referral Title:	03.Referral Primary Phone #:	04.Ext:
05. Referral's Facility Name:	06.City:	07.State:	08.Zip:
09. Judicial County:	10.Email:		

By placing my signature below I recommend this client to receive a substance use disorder assessment and necessary treatment to include recovery support services as part of his/her treatment plan.

11.Referral Authorizing Signature:	12.Date:

SECTION F: REQUESTED SERVICES

01. Treatment Provider Name:	02.Treatment Level of Care:	03.Site/City
04.Recovery Support Service Provider:	05.Service Type:	06.Site/City
07.Recovery Support Service Provider:	08.Service Type:	09.Site/City

10.List additional services requested here:

11.Restate Client's Full Legal Name:	12.Intake Submission Date: